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# Substance Abuse Among the Deaf Population: An Overview of Current Strategies, Programs & Barriers to Recovery

Katherine E. Lane
*Office of Vocational Rehabilitation Bowling Green, Kentucky 42101*

# SUBSTANCE ABUSE AMONG THE DEAF POPULATION: AN OVERVIEW OF CURRENT STRATEGIES, PROGRAMS & BARRIERS TO RECOVERY

**Katherine E. Lane**
**Office of Vocational Rehabilitation**
**Bowling Green, Kentucky 42101**

Approximately 5% of the people in the United States cannot voluntarily control their drinking (McConnell, 1986). Among children aged 12 to 17, 70% have experimented with alcohol and drugs, while an estimated one-third use or abuse these drugs regularly (Kapp et. al., 1984). Estimates of the incidence of substance abuse (Note 1) within the deaf (Note 2) population vary widely. Steitler (1984) estimated that more than one million deaf Americans need substance abuse counseling, while the National Institute of Alcohol Abuse and Alcoholism estimates only 73,000 deaf alcoholics (McCrone, 1982). Other investigators report incidence levels of substance abuse among deaf people ranging from 7% to 20%. Furthermore, approximately one-fourth to one-third of all deaf Americans with mental health problems suffer from substance abuse (Steitler, 1984).

Comparisons of the abuse of substances within the deaf and hearing populations range from a lower incidence among deaf substance abusers (Adler, 1983) to a greater risk among disabled individuals (Steitler, 1984). The majority of the research, however, indicates that deaf people face at least the same risk of alcoholism and drug abuse as do their hearing counterparts (Isaacs et. al., 1978).

### Precipitating Factors Leading to the Abuse of Substances

Cultural, social and psychological factors combine to contribute to an individual using or abusing substances. Stein (1985) proposes that familial, institutional, cultural and other dynamics prevent social problems from being solved, so people "solve" their problems in a culturally-approved manner: consumption of alcohol. Linsky et. al. (1985) explain the phenomenon of alcoholism by examining socially induced stress and tension in a society that permits the use of alcohol for releasing that tension. Comparing social stress and normative approval of alcohol in several western states, Linsky et. al. found that alcohol problems are greatest within the context of strong cultural support for the use of alcohol.

Alcoholism is a cultural phenomenon. Americans are bombarded daily by commercials, billboards and magazine advertisements associating alcoholic consumption with success, youth, sex, and peer acceptance. Clearly, alcohol consumption is an accepted form of recreation.

Researchers also attempt to explain the use and abuse of substances by examining the abuser's psychological makeup. Distinguishing between experimentation, recreational use, and abuse of substances, investigators find numerous reasons for use, including curiosity, peer pressure, rebellion from parental authority, and more. Beyond these are the reasons for abuse of substances. Substance abusers are commonly found to exhibit feelings of insecurity, inadequacy, worthlessness, loneliness, a deep sense of isolation from others, immaturity, irresponsibility, lack of confidence, egocentric orientation and poor family relationships (Steitler, 1984; Grant et. al., 1983; Jorgenson & Russert, 1982).

Steitler (1984) examined drug and alcohol abuse among disabled individuals. Suggested reasons for the abuse of substances among the disabled population included: (1) easy access to drugs and widespread resistance among educators, parents and others to recognizing the warning signs; (2) abuse of substances occurs in an attempt to manage frustration and anxiety; (3) disabled people are an oppressed minority, and alcohol and drugs promise numbness and relief; and (4) substance abuse may result from medical intervention and the rehabilitation process.

Among deaf substance abusers in particular, researchers have found certain commonalities. Deaf alcoholics frequently have little trust in themselves or in others (Grant et. al., 1983). Deaf adolescent substance abusers are more externally controlled, submissive to peer pressure, and dependent on the opinions of others; and they exhibit poor impulse control, poor communication skills, depression, immaturity, and

intense feelings of isolation and inferiority (Note 3; Steitler, 1984).

Deafness has been termed the "lonely handicap" while alcoholism has been nicknamed the "lonely disease" (Wentzer, 1986). Deafness can isolate individuals from mainstream society because of the language and cultural differences that result from the handicap. The largest single cultural group within American society may be deaf individuals who use American Sign Language as their native language (Steitler, 1984). Since language is the bearer of culture, this population develops and maintains a separate culture. As a result of these language and cultural differences, deaf people may be excluded from normal interaction in the world. Limited communicative ability can mean that social functioning for that deaf individual is always on a limited basis (Hetherington, 1979). Consequently, deaf alcoholics may be doubly isolated from society because of both their alcoholism and their deafness. They must overcome not only the effects of deafness, but also of a disease which encourages isolation.

It appears, then, that substance abuse is a widespread problem in this country, that deaf people abuse substances at least as often as hearing people, and that there are a variety of known precipitating factors which can lead to substance abuse. Once an understanding of these basic issues about substance abuse has been reached, recovery issues can be addressed.

**Barriers to Recovery**

The deaf acoholic faces numerous barriers to recovery. First of all, there are few treatment centers competent to treat deaf alcoholics. Secondly, deaf alcoholics are widely geographically distributed. Thirdly, few personnel at treatment centers are skilled in both deafness and alcoholism. Also, the "small town" mentality of the deaf community strongly stigmatizes the deaf substance user. In addition, after lifetimes of being poorly treated by hearing people, deaf people often mistrust hearing professionals. Another problem is lack of information about resources and sources of funding. A final but critical factor is the communication barrier. Each of these factors will be examined in detail.

Isaacs et. al. (1978) found that, despite the fact that deaf people are at serious risk to substance abuse, few specialized services exist. Although alcoholism treatment services have grown enormously, as Rothfeld (1983) put it, "... despite this preponderance of treatment, there is at least one segment of the alcoholic population which has been virtually unserved; the deaf alcoholic" (p. 79). Boros (1983) traces the slow development of specialized services for deaf alcoholics in the United States. Not until 1968 was there a published reference to deaf alcoholics, and the first treatment program targeted for this population opened in 1973. It was not until 1975 that a conference was held on alcoholism among deaf people. As a result, many early programs developed independently of each other, thus wasting precious time and energy duplicating solutions to problems.

A second barrier to treatment is the wide geographical distribution of deaf alcoholics. Because this population is scattered throughout the country, treatment becomes less accessible. Rothfeld (1983) proposes state and national outreach and referral networks. Not only would these networks gain referrals, he argues, but they would also be an excellent source of gaining new knowledge about working with deaf alcoholics (Note 4).

The shortage of skilled personnel poses a serious problem. Alcohol agencies are designed for hearing clients and are rarely staffed with counselors who understand deafness (Watson et. al. 1979). At the same time, experts on deafness may refuse to work with deaf alcoholics because they lack the necessary expertise in alcoholism (Boros, 1979). The deaf alcoholic faces a "double whammy." Deaf abusers who manage to overcome accessibility barriers and enroll in a treatment program often find few personnel knowledgeable about deafness and even fewer skilled in manual communication. Consequently, the counselor usually cannot truly understand the deaf patient nor communicate effectively.

Another barrier faced by the deaf abuser is the labeling that frequently occurs within the deaf community. Where it is an isolated group of people, the deaf community may be small, conservative, and ready to label its members. Once the community brands an individual as a drunk, this label is difficult to shed (Note 5).

According to Wentzer (1986), the "deaf alcoholic usually feels helpless to change his image within his community" (p. 15). Alcoholism is often regarded as a "moral weakness" and "shameful sin" in the deaf community (Boros, 1979), and knowledge that alcoholism is a treat-

able disease is frequently lacking. In addition, the gossip network may strongly discourage individuals from public admission of any aberrant behavior. Since the first step towards recovery is acknowledging the existence of the problem, the deaf alcoholic is at a distinct disadvantage when faced with moral pressure and lack of support from the deaf community. As Boros (1979) says, "Social control forces within the deaf community tend to maintain a secretive seclusion of the deaf alcoholic in an untreatable condition" (p. 1).

Yet another barrier to recovery is the deep suspicion which deaf people often harbor for hearing people. The deaf population is, unquestionably, an oppressed minority. Negative experiences with hearing individuals often lead deaf persons to become mistrustful of hearing people as a group. Thus hearing professionals at treatment centers must spend extra time building trust and orienting deaf clients to the therapeutic service.

The lack of information about resources and sources of funding compounds the problems to recovery. Vocational Rehabilitation may assume the cost of treatment programs on occasion, if: (1) the abuser is a client of the agency, and (2) the V.R. counselor determines this is a necessary and appropriate service. If the abuser has insurance, participation in a treatment center may be an allowable cost. In addition, some treatment centers have funds available to assist indigent patients. Unfortunately, many abusers do not meet the necessary requirements to receive assistance from the above sources of funding. Those unable to afford the expense on their own typically remain unserved. Another funding issue concerns the cost of interpreters at Alcoholics Anonymous and Narcotics Anonymous meetings.

The single largest problem faced by deaf substance abusers, as well as by deaf people in general, is communication. AA's basic slogan, "Call before you pick up your first drink," poses a real problem for deaf alcoholics. Not only do a limited number of deaf alcoholics have TDD's, but few treatment centers own these devices. A more serious problem resulting from the communication barrier occurs in counseling sessions. The inability to communicate freely and easily inhibits meaningful therapy. In addition, the language barrier makes it difficult to assess the deaf patient, so the therapist is left wondering about the patient's precise skills and limitations. In counseling sessions interpreters are frequently used. However, this may threaten the confidentiality and integrity of the therapeutic relationship (Watson, 1983). Furthermore, interpreters are often mistrusted, either because of preconceptions about interpreters, because the interpreter is hearing, or because the interpreter is known to the patient (Wentzer, 1986). Unbelievable as it may seem, family members of the patient are often used as interpreters. Other problems in using interpreters include the difficulty in securing a single interpreter for enough hours at convenient times, and the fact that many interpreters lack sufficient skills. It is strongly advisable to use an interpreter with extensive experience in alcohol and drug abuse interpreting. Even better is an interpreter who is recovering her/himself or who participates in Al-Anon. Obviously, such interpreters are few and far between.

A major component of many alcoholism treatment programs is participation in AA group meetings. The personal testimonies are a crucial part of the recovery process. Although involvement in AA can be done on a limited scale using interpreters, the deaf alcoholic cannot gain the full benefit of these encounters (Rothfeld, 1983). Integrated AA meetings (consisting of both recovering hearing and deaf alcoholics) are advocated by some, whereas AA meetings comprised of only recovering deaf alcoholics are supported by others.

Not only is the counseling relationship strained and the group interaction limited, but the language of the basic concepts of AA that are so essential in liberating the compulsive abuser may be beyond the deaf alcoholic's comprehension. AA literature was written **BY** hearing people **FOR** hearing people. The difference in language between hearing and deaf people often means an additional problem for the deaf alcoholic. In order to understand the concepts, the deaf alcoholic may first need to learn a new word, then a new sign for that word, then a meaning for that word (Wentzer, 1986). This can be an overwhelming task and the individual often experiences overload. It simply takes more time for the deaf patient to assimilate all that information. Woodward (1980) wrote a book standardizing basic signs used in explaining alcohol and drug terms to deaf people. Additionally, AA literature is currently being rewritten so that it will be more meaningful for the deaf alcoholic. Considering the many barriers discussed, it is clear

that making substance abuse services accessible to deaf clients requires more than simple knowledge of deafness and sign language.

**Treatment Centers, Programs and Services**

As of 1983 there were only a total of ten substance abuse treatment services in the United States for deaf clients (Watson, 1983). While there has been some growth in services during the last five years, this number has not increased dramatically. A description of some of these programs follows.

Project AID (Addiction Intervention for the Deaf) serves about 25,000 deaf people in nine counties of Northeast Ohio. The goal of AID is to assist deaf people in obtaining relevant services from alcoholism agencies (Boros, 1983). Rather than offering separate treatment facilities, AID identifies deaf people in need of treatment for a drinking problem and prepares them for a 28-day treatment program in the hospital. Working with a number of hospitals, AID assists the client in admission procedures. At many hospitals AID staff are actually a part of the admissions team, offering suggestions and providing input. AID provides interpreters, helps with exit staffing, does follow-up and reports to the hospital on the client's progress. Boros (1983) discusses at length the details of coordinating and providing services through the hospitals.

CCAIRU (Cape Cod Alcoholism Intervention and Rehabilitation Unit) Project for the Deaf is a residential and outpatient unit on Cape Cod in Massachusetts. A highly structured and intensive program, CCAIRU Project for the Deaf allows deaf alcoholics to participate in a program with their peers and "come to grips" with their alcoholism and with the problems associated with deafness (Rothfeld, 1983). Clients participate in two group processes each day and receive individual counseling at least twice a week. An essential component of the program is involvement in AA with hearing persons, through the use of highly skilled interpreters. Recreational, vocational rehabilitation, educational and life skills training are provided to prepare the client for the transition to a self-sufficient life in the community. Extensive and careful training in after-care strategies is provided. Involvement with local clubs for the deaf is required. Support groups are widely used to address the problem of low self-esteem. The center has a 24-hour TDD hotline and a deaf counselor is always available. The CCAIRU Project for the Deaf also has an innovative new program involving a visual form of therapy (Note 6).

SAISD (Substance Abuse Intervention Services for the Deaf) at Rochester Institute of Technology provides deaf alcoholics accessibility to community-based agencies delivering services in substance abuse. This agency also gives technical assistance and educational information to community agencies in the area of deafness. In addition, SAISD provides intervention counseling as well as referrals (Boros, 1983).

The St. Paul-Ramsey Hospital Mental Health Hearing-Impaired Program is described by Scanlon (1983). Currently only functioning on an in-patient basis, this is a 21-day treatment program.

In an effort to provide information about substance abuse to deaf individuals, the Community Outreach Program for the Deaf (COPD) in Tucson, Arizona developed a co-counseling arrangement with alcoholism experts (Jorgenson & Russert, 1982). A committee of interested parties was formed to conduct educational workshops. Targeting the lack of alcohol information in the deaf community, the workshops were designed for both professionals and students (Ferrell, 1984).

In 1983, a substance abuse prevention and education program was developed at the Kansas School for the Deaf (Kapp et. al., 1984). The goals of this program were to determine the incidence of substance abuse among the student population, assess the amount of information students possess, and inform the students about drugs and alcohol. A questionnaire survey was used to gather information, and small group discussions were the format for disseminating information.

In addition to these programs, other types of services are gradually developing. Listings of all AA meetings across the United States which are interpreted for the deaf are now available. The central office of AA has distributed information to all AA groups detailing the specific needs of deaf alcoholics. Finally, in 1983 the National Institute of Alcohol Abuse and Alcoholism (NIAAA) mandated an initiative program for all disabled persons, thus making targeted grants available (Boros, 1983).

Very little has been written about the degree of success achieved at treatment programs for deaf

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substance abusers. Only two articles briefly mention recovery rates, and neither one in reference to specific treatment centers. One researcher found a recovery rate of 70% among deaf alcoholics in contrast to a 40% recovery rate among hearing alcoholics (Hetherington, 1979). The other article also affirmed that deaf alcoholics recover at a higher rate than do hearing people in the same program (Boros, 1983). Since treatment centers targeting deaf substance abusers have been in existence for less than fifteen years, perhaps literature on the success rate of these programs will be forthcoming.

Because existing programs are developed by hearing people and for hearing people (Adler, 1983), this presents special problems for the deaf alcoholic. As previously discussed, the deaf substance abuser may face multiple pressures, including social isolation and loneliness, difficulties in personal relations, lack of education, and an inability to hold a job (Stewart, 1983). In essence, the deaf substance abuser faces all of the problems of the hearing substance abuser and more. There are a variety of steps which can be taken to work towards prevention of substance abuse among deaf persons and to improve the quality of services at treatment centers.

First of all, Steitler (1984) urges identification of the potential abuser at an early age. Since specific psychological characteristics have been correlated with substance abuse, Steitler recommends "predicting drug use behavior based on the presence of clusters of risk personality attributes" (p. 169). Once potential abusers are identified, educators and counselors can intervene.

Support services are critical in the recovery process of substance abuse. While support services such as Alanon, Alateen and Alatot are available for the hearing community, no such groups exist for the deaf community (Scanlon, 1983). Many people maintain that these groups are most effective for the deaf individual if they are composed of other deaf persons. Further, these support services need to continue after completion of the treatment program. On a related note, comprehensive follow-up is essential to ensure that the deaf client does not resume former abusive behaviors.

Rothfeld (1983) recommends that deaf counselors be hired at treatment centers for deaf substance abusers. Not only will this foster greater communication, but the patients will be provided with positive role models.

Much of the literature discusses specific counseling procedures with the deaf substance abuser. The goal of counseling is to convey a basic sense of self-worth to the client (Grant et. al., 1983). Often the deaf substance abuser has labelled her/himself as a failure and has severed societal ties, thus limiting his/her options. In treatment these feelings of frustration and anger about deafness need to be addressed, along with accompanying lack of self-motivation to seek treatment, reduced social competence, etc. (Steitler, 1984). Cassell and Darmsted (1983) found many similarities in working with deaf and hearing abusers. They claim that intervention was most effective when focusing on present issues rather than abstract childhood or future events. Other articles provide necessary information to the counselor about methods of working with an interpreter and basic differences between deaf and hearing persons, such as in body language, which can be easily misconstrued (Wentzer, 1986; Boros, 1983; Chough, 1983; Jorgenson & Russert, 1982; McCrone, 1982).

Additional recommendations by researchers include: federal funds for the training of counselors to work with deaf persons in the area of substance abuse; federal support for substance abuse education and prevention in the deaf community; public education commercials in sign language about substance abuse; required continuing education courses in substance abuse for the teaching staff and support personnel at schools for the deaf; information centers stocked with current material on substance abuse at schools for the deaf (Locke, 1979).

Watson (1983) believes that the slow development of special services and scientific research in the area of substance abuse among the deaf population results from the lack of a theoretical base in dealing with deaf substance abusers. Unquestionably, a great deal of research needs to be done. The incidence and patterns of substance abuse among deaf persons need to be investigated. In addition, existing treatment programs for deaf substance abusers need to be analyzed. Recovery rates must be determined and treatment methods must be compared. Lastly, services and treatment programs must be made available to the thousands of deaf substance abusers who remain unserved.

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## NOTES

1. Since alcohol is by far the most commonly abused substance (McConnell, 1986) and since many individuals today are cross-addicted (using both alcohol and drugs) (Boros, 1983), this paper will examine the combined category of substance abuse.

2. For the purposes of this paper, "deaf" is defined as the inability to function through hearing alone, with or without a hearing aid.

3. Steitler (1984) suggests that deaf adolescents who are substance abusers have extremely difficult family situations, and are often "programmed for failure because of their disability" (p. 172). In other words, hearing parents of a deaf child frequently assume the child will fail and rear the hcild with this expectation. Steitler goes on to discuss the critical time that adolescence is for personal development. Adolescence brings with it certain psychosocial crises which need to be resolved. For the deaf youth, working through these problems can be an immense task. Self-esteem and self-confidence plummet when the deaf youth experiences repeated failures at task accomplishment. Troubled adolescents often resort to alcohol and drug use in order to deal with this environment and avoid personal problems. Stress and its management play a key role in propensity toward substance abuse. Individuals with good self-concepts and self-acceptance maintain confidence in their ability to manage their lives. Therefore they are more flexible and assertive in dealing with stress and do not resort to drugs.

4. The appropriate networking of services is a murky area. A program established to work with deaf alcoholics will often get referrals on anything having to do with deaf people. Because mental health and substance abuse are closely related fields, overlap will occur, despite existing separate facilities. According to Scanlon (1983), services for deaf people cannot be split as they can be for hearing people. In contrast, Watson (1983) argues that boundaries must be established. An agency that tries to do "all things for all deaf people" will violate the trust of the deaf community. Scanlon (1983) counters that it is better to have one agency provide all the services to avoid confusion and ensure that quality services are received.

5. This harsh treatment is perhaps understandable. A deaf drunk, like a deaf panhandler, is an embarrassment. The deaf community is sensitive to the fact that hearing people will frequently form opinions concerning all deaf people, based on the impression of only one deaf person.

6. "Creative programming is being developed in the areas of art and drama therapy. In small groups, clients are asked to draw pictures which reflect their expriences as drinking alcoholics, and as deaf human beings struggling in a hearing world. Each client then explains his or her drawing in mime or sign language... Response to this visual type of therapy has been most positive, with a high degree of feeling involvement displayed, which was not previously evident in more traditional group processes" (Rothfeld, 1983, p. 31).

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